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Title

Analysis of sexual healthcare provided by school nurses

Abstract

Aim: The aim of this study was to explore the role and activities of the school nursing service in sexual health within a large inner London borough. **Background:** School nurses (SNs) are specialist community public health nurses working with the school age population to promote their health and wellbeing (Department of Health (DH), 2014a) and therefore are arguably in a prime position to promote the sexual health of children and young people. This is particularly pertinent in inner city boroughs where the rates of sexually transmitted infections and under 18 conceptions are a significant problem. **Methods:** Following a review of the literature, a mixed methods study was undertaken which included an audit of documentary data to identify the referrals received in relation to sexual health and also included questionnaire surveys of school staff and school nurses on their views of the role of the school nurse in sexual health. **Findings:** School nurses and school staff identified that school nurses have a role in sexual health, which was reflected in the referrals received during the audit of documentary data. There appeared to be inconsistencies across the service and evidence suggested that the school nursing service may be underutilised in comparison to the number of students who require sexual health support. The current service appears to be predominantly reactive, particularly for males and those less than twelve years old. However, both school nurses and school staff would like to see a more preventative approach; including greater sexual health promotion, condom distribution and school health clinics.

Key words:

Sexual health; School nursing; Sexually transmitted infections; teenage pregnancy;

Background

Improving sexual health outcomes for young people is a national priority for the UK government (Public Health England (PHE), 2015a). This includes reducing the rate of sexually transmitted infections (STIs) which are currently on the rise, with around 440,000 new diagnoses made in England in 2014 (PHE, 2015b). STIs are a public health issue associated with infertility, cancer, and psychological and social difficulties (World Health Organisation (WHO), 2013). The Government's sexual health priorities also include tackling teenage pregnancy, which is linked with increased likelihood of infant mortality, childhood accidents and living in deprivation (Moffitt, 2002) and is estimated to cost the NHS £63 million annually (Department of Health (DH), 2009a). School nurses (SNs) are specialist community public health nurses working with the school age population to promote their health and wellbeing (DH, 2014a). These specialists are qualified nurses with an additional specialist public health qualification. However, there is no requirement that their preparation programmes contain sexual health education, so the knowledge base of qualifying practitioners will vary. There are only just over 1,000 school nurses across the UK, supporting approximately nine and a half million children and young people (RCN, 2016). To deliver a comprehensive service, school nurses are supported by community staff nurses working across groups of schools rather than working in one school. In England since 2012, the service has been commissioned by Local Authorities, which has resulted in a variable level of service delivery (Royal College of Nursing (RCN), 2017). As public health nurses working with this population they are arguably in a prime position to promote the sexual health of children and young people. The DH (2014b) identifies that SNs have a role in sexual health including developing school-based health services, delivering sex and relationships education and offering condom distribution schemes.

Sexual health has been a major feature in national public health policy since the release of the Teenage Pregnancy Strategy (Social Exclusion Unit, 1999). Most recently the Local Government Association (2016) report 'Good progress but more to do: teenage pregnancy and young parents', highlights that although the under-18

conception rate has halved since 1998, it remains high compared to other countries in Western Europe and across UK boroughs there is a large variation in rates of teenage pregnancy which has contributed to health inequalities. In the London borough which formed the focus of this study the conception rates are 27.4, which is significantly higher than the London average of 21.5 for under-18 conceptions and the England average of 22.8 per 1000 for 15-17-year olds (Office for National Statistics, 2016). The borough also had a significantly higher rate of diagnosis of STIs including chlamydia in the 15-24 year age group in 2014 compared to the London average (PHE, 2016). With regard to STI's (excluding chlamydia diagnoses in the 15-24 year age group), in 2014 2465 per 100,000 diagnoses were made in the Borough, compared to the London average of 1534/100,000 and the England average of 829/100,000 (PHE 2016). Data from 2014 shows the Borough to have the 5th highest rates of chlamydia diagnosed in the population aged 15-24 in London, with chlamydia being detected in 3,241 out of 100,000 15-24 year olds (PHE 2016).

A scoping review of the literature was undertaken to identify the breadth of research available, this followed the approach and steps developed by Arksey and O'Malley (2005). The scoping review identified 18 papers published between 1999 and 2016, these were published in the UK, USA and South Africa and revealed that school nurses (SNs) are perceived to have a variety of roles within sexual health. These include delivering sex and relationship education (SRE) (McFayden, 2004; Jones, 2008; Brewin *et al.*, 2014), leading drop-in clinics (Richardson-Todd, 2006; Ingram & Salmon, 2010), supplying contraception (Richardson-Todd, 2006; Ingram & Salmon, 2010), including emergency contraception (Richardson-Todd, 2006; RCN, 2012), and referring to other services (RCN, 2012; Dittus *et al.*, 2014). McFayden (2004) identified that although the majority of school nurses in their UK based study viewed themselves as having a role in sex education, many lacked confidence in this area in contrast to a small American study by Brewin *et al.* (2014) which found that SNs felt comfortable in this role. McFayden's findings may be reflected in those of Reid & Teijlingen's (2006) UK focus group study with young people, where SNs were generally viewed as poor sources of information. However, healthcare facilitators such as SNs were preferred over teachers to deliver SRE.

Although some young people view SNs as a poor source of sexual health information, a British Youth Council (BYC) (2011) online survey completed by a sample of 1599 young people aged 11-18 in England found that advice on contraception, STIs and referring to other services were listed in the top five services young people felt SNs should provide. The perception that SNs do have a role in sexual health has further been supported in a case study by France (2014), where a SN text messaging service was established in two UK secondary schools, with 56% of text messages received from students being related to sexual health.

The view of school staff regarding the sexual health role of school nurses is under researched. However, in a questionnaire completed by 86 UK secondary school Personal, Social, Health Education (PSHE) coordinators and head teachers on emergency contraception, 55% reported that they would inform their SN if a fourteen-year-old asked for emergency contraception, suggesting they perceive the SN to have a role in this area (Graham *et al.*, 2000). Overall there seems a consensus in the published literature that young people, teachers and parents value the contribution of the SN with SRE (Jones, 2008; BYC, 2011).

Collaboration was recognised as an important area to examine within the literature, to explore the importance of student and staff input in directing the planning and delivery of school health services. Working in collaboration with the school age population has been identified as important for sexual health service development. Reid & Teijlingen (2006) in their Scottish study argue that the views of young people should be considered when planning and delivering SRE as generally their participants viewed SRE as outdated and ineffective. Hayter *et al.* (2012) further supported this by highlighting the importance of involving young people in service design and evaluation to promote attendance and a user-friendly service. Collaboration also needs to extend to school staff and parents, some of whom have expressed a fear that the service will lead to increased sexual activity amongst young people, which can act as a barrier to service delivery (Schmiedl, 2004). Hayter

et al. (2012) found that such opposition can be tackled through consultation with parents, head teachers and governors.

Owen *et al.* (2010) and Hayter *et al.* (2012) found that school nurses delivering a holistic approach, incorporating sexual health, promoted access to sexual health services by minimising sexual health associated stigma. In a systematic review exploring young people's views on school sexual health services, the offer of free condoms, increased opening hours, a convenient but private location and knowledge of a confidential service, were all found to improve access (Carroll *et al.*, 2011). Interestingly, the BYC survey (2011) revealed 39% of young people felt unsure if their confidentiality would be maintained, potentially creating a barrier to access. A barrier which potentially could be overcome through a text messaging service as 76.2% of survey respondents in France's (2014) study felt the texting service was a good way to seek health advice.

Method

This study aimed to explore the role and activities of the school nursing service in sexual health within one London borough. Objectives:

- 1) To establish the number and nature of referrals received by the school nursing service in relation to sexual health.
- 2) To identify the views and experiences of school nurses, using a questionnaire survey, on their role in sexual health, the service they currently deliver in this area and the factors that hinder service delivery.
- 3) To identify the views and experiences of school staff, using a questionnaire survey, on the school nurses' role in sexual health, the service they currently receive and factors which stop them from using the service.

Ethical approval was gained from a London University and permission was granted from the NHS Trust providing school nursing services within the borough. As this study aimed to assess existing practice (Mateo & Foreman, 2014) a mixed methods approach was taken gaining quantitative and qualitative data through an audit of documentary data and questionnaire surveys to explore existing school nursing practice in the borough, related to sexual health. Three teams of school nurses across the borough were trained in the use of an audit tool which had been developed by the authors. The audit was then undertaken for a three-month period to identify the nature of the referrals related to sexual health. Although the audit tool had not been previously validated it was designed based on the scoping review of literature and the authors' experience of school nursing practice. The inclusion criteria for the audit are outlined in Table 1.

Following permission from the service manager for school nursing and head teachers within the borough's 21 secondary schools, a SurveyMonkey (SurveyMonkey Inc. 2017) web link was emailed to all school nurses working in secondary schools in the borough (n=8) and a different web link was emailed to a member of staff in each secondary school, identified by the head teacher as the most appropriate person to complete the questionnaire (Appendix 1 & 2). The roles of these staff included deputy head teachers, inclusion managers, special educational needs co-ordinators and safeguarding officers. Although it could not be guaranteed who completed the survey by aiming for a staff member who was actively working with the school nursing service, it was hoped that a realistic picture would be gained. As such a purposive sample was sought to gain the most meaningful information (Holloway and Wheeler, 2010) and the use of the SurveyMonkey ensured anonymity which was important considering the small size of the samples. To ensure school nurses did not feel coerced into participating, the school nurse service manager, acting as gatekeeper, rather than the researchers contacted staff members informing them about the study and provided an information sheet. The service manager asked that staff willing to participate contact one of the authors to gain the web link. All eight school nurses participated giving a

100% response rate and nine teaching staff, giving a 42.8% response rate. Although the latter is low it is an acknowledged limitation of self-completion questionnaires (Parahoo, 2014). The small population size prevented pre-testing of the surveys, however, these were scrutinised by the all members of the project team, the Trust's research and development lead and the university's ethics committee. The two questionnaires (Appendix 1 & 2) included nine questions. In the SN survey there were seven forced choice questions with some space for comments, plus two open ended questions seeking SN participants' perceptions of barriers and areas for development regarding their role in sexual health. The teaching staff survey included space for additional comments on the closed questions and one open ended question asking what further support or input would be valued from the school health service related to sexual health.

Data were analysed using quantitative and qualitative methods. The audit data and the closed and multiple-choice questions on the surveys provided numerical data regarding the input provided from the school nursing service in relation to sexual health. The data produced from the closed questions was mostly nominal, with one question self-rating confidence for both school staff and school nurses, which produced ordinal data. Descriptive statistics were used to analyse the data. The open-ended survey questions produced a limited amount of qualitative data, which both researchers analysed by reading several times to identify participants' perceptions of barriers and developments regarding sexual health services. This data added depth to the quantitative data by the small sample of survey participants (Holloway and Wheeler, 2010).

Findings

Audit:

The audit of documentary data took place over a three-month period and monitored referrals received by the school nursing service in relation to sexual health from accident and emergency departments, the safeguarding children's team, schools

and self-referrals via the school nurse drop-in. During this time, a total of forty-six referrals were received by the school nursing service in relation to sexual health.

Over a third (37%, n=17) of the total referrals received by the school nursing service in relation to sexual health were from the safeguarding children's team or children's social care, including ten (58.9%) related to child sexual exploitation (CSE). Accident and emergency departments were the least common referral source with just seven referrals (15%) received over the three-month period. These data are consistent with the information provided by both school nurses and school staff that safeguarding children and young people was identified as a main role of school nurses within the context of sexual health. The majority of drop-in attendances were for sex and relationships education/sexual health promotion (n=10, 70%), including advice on STIs and contraception, which is perhaps reflective of the self-referral nature of the drop-in service. The referral reasons from accident and emergency departments and schools were much more sporadic and included referrals requesting support with teenage pregnancy, referring to other services and safeguarding issues. The specific reasons for referrals are outline in Figure 1.

The teenage pregnancy referrals along with those for safeguarding are perhaps suggestive of a more reactive provision of sexual health support from the school nursing service. Only a quarter (28%, n=13) of referrals were related to sexual health promotion which may be considered a more pro-active area of support; with an aim of preventing STIs, teenage pregnancy and promoting healthy relationships.

Regarding gender just 15% (n=7) of the referrals received by the school nursing service were regarding males. Considering that the borough's school age population is close to 50% males this suggests that they are underrepresented with regard to the sexual health referrals received by the school nursing service. No males were recorded to have attended the school nurse drop-in for sexual health support during the audit period and no sexual health referrals were received from accident and emergency departments regarding males; suggesting that the young male population

in the borough are not accessing sexual health support from the school nursing service. Eighty five percent of referrals relating to males were regarding a safeguarding issue including five (71.4%) CSE referrals. This finding highlighted further that particularly for the male population the majority of referrals indicate a reactive sexual health provision.

Regarding age, 70% of referrals received by the school nursing service were related to young people aged thirteen to fifteen (n=32), Figure 2.

Children aged twelve and under comprised just 10% of the total referrals received (n=5); with all referrals for children within the under 11 and 11-12 age category related to CSE. This highlights the need for PSHE for primary school age children to incorporate age appropriate information on CSE and healthy relationships.

School nurse survey: responses to closed questions

From the school nurse survey responses to the closed questions, it was identified that all eight school nurses recognised that they had an active role in sexual health, with all stating this role involved safeguarding and the HPV vaccination programme. Five of the school nurses reported that they had supported between one and nine young people within the previous month where sexual health was the main focus of contact. In addition, one further school nurse reported that sexual health support was offered as part of a broader health assessment. Overall the school nurses reported supporting a mean estimate of 2.68 students in the past month where sexual health was the main focus of the contact, compared to a mean estimate of 8.13 students who were reported to have received sexual health support as part of a broader health review with the school nurse. On the whole, the type of contact was reportedly one to one rather than group SRE sessions. Only four school nurses had offered group sessions during the previous year with only one school nurse delivering more than four sessions. These data suggest inconsistencies in service delivery.

All the school nurses reported that they had received training in the last five years to support children and young people with sexual health. However, when asked to rate their confidence in this area of practice only one school nurse rated themselves as being very confident on a scale of 1-5 (with one being not confident at all and five meaning very confident), the other seven school nurses rated themselves between one and four. Unsurprisingly the school nurse who reported undertaking the most group sessions also reported having the highest confidence in this role.

School staff survey: responses to closed questions

Similarly, to the survey for school nurses, all nine school staff respondents identified school nurses as having a role in sexual health in response to the closed survey questions. They were also more likely to view school nurses as having a role in delivering sex education to students on a 1:1 basis (100%, n=9) compared to group education (66.67%, n=6). This may be related to the frequency that support is observed based on the findings from the school nurse survey.

School staff were asked to identify the number of students they had been aware of in the last month who had required sexual health support, the number they had referred to the school nursing service and the number they had encouraged to attend the school nurse drop-in. The findings indicated that not all students requiring sexual health support are referred to the school nursing service or encouraged to attend the school nurse drop-in clinic (Table 2).

The survey responses suggested that school staff were aware of a mean estimate of 3.77 students who had required sexual health support in the last month, yet out of these students, 55.56% (n=5) of respondents had not referred any to the school nursing service. This suggests that although some students are referred to the

school nursing service for sexual health support, it does not reflect the number that school staff know require support. A third of respondents identified that they had encouraged students to attend the school nurse drop-in. However, one respondent added a comment that they could not do this because the service was not available in their school.

The most common requests for support from school staff related to safeguarding and referring students to other services (62.5% (n=5) of respondents). This correlates with the perception by school staff where 88.89% (n=8) identified that school nurses have a role in safeguarding and referring students to other services. In this context, safeguarding is recognised to be a broader term than 'child protection,' relating to the promotion of children's welfare of children and their protection from harm (Department for Education, 2015). Interestingly, only 44.44% (n=4) of respondents reported that their school had received support with SRE from their school nursing service in the last year. Two respondents ticked that they received SRE from another agency which may help to explain this figure.

Closed question responses also indicated that the most common reason for school staff not involving the school nursing service, identified by three respondents, was that other services are available to support students with sexual health. These services include local sexual health clinics and clinics for the under 25's. One respondent ticked that the school nurse is not always available and another that the length of time taken for the school nurse to act upon the referral is too long. This links to the barrier of time identified by some of the school nurses completing the questionnaire survey. Interestingly, one respondent ticked that they felt their school did not need support in the area of sexual health.

Qualitative survey data:

A small number of open ended questions were included in the survey, these explored the barriers to providing sexual health services and the developments school nurses and teachers would like to see in this area of activity. Four barriers were identified, along with lack of confidence mentioned by one school nurse, which was also highlighted by the quantitative data. The other barriers were lack of resources (1 respondent), difficulty getting school staff on board with services such as condom distribution and SRE delivery (2 respondents). The main barrier raised was lack of time to deliver a sexual health service (3 respondents), with one respondent whose view was reflective of the other two stating:

‘Supporting schools with the preparation and teaching around sexual health is very time consuming, [there is] not enough staff, time, etc.’

Seven of the school nurses reported that they would like to see their role in sexual health develop. Their suggestions, included expansion of the service to enable school nurses to offer pregnancy testing, testing for STIs and condom distribution, are summarised in Table 3.

When asked what could support these aspirations for a developed service further training was the main need reported (Table 4).

Schools said they would like their school nursing service to provide more sex education sessions, small group work with young people identified to be at risk of STIs or pregnancy and a school health clinic to support more young people to self-refer for support, advice and help from the school nurse.

One respondent commented that a high staff turn-over prevented them from utilising the school nursing service, with another respondent stating:

‘I feel that we get a very good service from the school nurse team when the school nurse is available, but we do have trouble at times due to staff shortages.’

This highlights the issue of the importance of school nurses having the time to build consistent relationships with their schools to enable service delivery, which was raised by one school nurse. School nurses working collaboratively with education staff and parents underpinned many of the aspirations and wishes mentioned within the survey responses. This is reflected in the comment of one respondent:

‘School nurses building relationships in schools through consistency as this role requires the school to trust the school nurse and the young people to be familiar with them. It can only be achieved if the school nurse is seen regularly working with the school to create a positive non-judgmental ethos in addition to confidential private spaces where young people can discuss their sexual health.’

Discussion

It appears that there is a variance in the provision of sexual health services delivered by school nurses across the world (Brewin *et al.*, 2014; Minguez *et al.*, 2015) the UK (BYC, 2011; Owen *et al.*, 2010) and within the borough from this study’s findings. This does not promote a vision of equality outlined by NHS England (2013) and may contribute to health inequalities. The differences in the borough’s sexual health service provision across the school nursing service may be explained by varying health needs across the community but could also be a reflection of the varying confidence and capacity of each staff member, or a lack of clear policy to set a standard for school nurses to adhere to in the area.

Where sexual health support is being provided by school nurses, findings suggest a more reactive service provision, with the majority of referrals received relating to safeguarding concerns or teenage pregnancy. The findings suggested that less time is spent delivering strategies such as sexual health promotion (accounting for 28% of referrals) and offering contraception (accounting for 0% of referrals). In line with the NHS five year forward view (National Health Service (NHS) England *et al.*, 2014), which argues that preventative healthcare is more cost-effective and contributes to better health outcomes for the population, a more proactive approach to sexual health service delivery may be a way forward for school nurses. This has been found to be beneficial in other areas, for example Ingram & Salmon (2010) evaluated a school-based drop-in service over a fifteen-month period where out of a total of 515 visits, 42% of young people attended for free condoms. Schmeidl (2004) argues that the availability of condoms in schools can increase condom use for young people and subsequently help to prevent pregnancy and the spread of STIs. Furthermore, a USA based study by Dittus *et al.* (2014) identified that providing school nurses with a referral guide to help direct young people to sexual health services, increased the uptake of contraception, STI testing and treatment for female students. Taking into account the views of young people, the BYC (2011) identified that young people age 11-18 want their SN to advise them on contraception, STIs and refer them to other sexual health services and Reid & Teijlingen (2006) found that young people want a healthcare professional to deliver SRE. This provides evidence that from the perspective of young people, they too would value a service that has a preventative approach.

The importance of collaboration with education providers in enabling sexual health service delivery was highlighted in the questionnaires completed by school nurses and school staff and appears particularly relevant to areas such as condom distribution, drop-in clinics and SRE, which are reliant on permission from school staff and parents to take place in school. Findings from the surveys and audit also suggest that although young people are able to self-refer through drop-in clinics, the school nursing service is mainly reliant on referrals to the service from other agencies, including school staff, to help them identify those in need of sexual health

support. This reliance highlights the importance of raising the profile and role of school nursing with such services, to instigate referrals, as findings from the surveys suggested that the service was underused in comparison to the number of students that school staff were aware of who needed sexual health support.

Carroll *et al.* (2011) identified that young people were not always aware of school nurse led sexual health services. A school nurse respondent to the survey identified that support from school staff to promote the school nursing service with students may increase access to the service for young people. This provides another example of how collaborative work with school staff may help to promote the provision of sexual health support by increasing attendance at school nurse drop-in clinics. This appears particularly important as the audit of documentary data identified that over a three-month period there were only ten attendances to the school nurse drop-in related to sexual health across the borough. This may also be related to other factors such as the timing of the drop-in and the suitability of the space in which the drop-in takes place, which have been identified as factors important to young people in promoting attendance (Hayter *et al.*, 2012).

Some young people within the borough are accessing the school nursing service for sexual health support, as evidenced in the audit of documentary data. However, in comparison to the estimated 50,900 young people aged ten to nineteen years living in the borough and the high rates of STIs and under-18 conceptions, it is considered that not enough people are accessing the service. Furthermore, a quarter of school staff survey respondents identified that they had not requested any sexual health support from their school nurse in the past year. The viewpoint of one teacher that sexual health support was not needed in their school is important to consider given the high rates of under-18 conceptions and sexually transmitted infections in the borough (PHE, 2016). Arguably if school staff do not perceive sexual health to be an area of need for their school they are unlikely to request or facilitate interventions such as sex and relationships education or condom distribution in school; thus, creating a barrier to service delivery.

Access was identified as being a particular issue for those aged under twelve and males, who were only referred for school nursing support following concerns of CSE. Interestingly, Dittus *et al.* (2014) found that referring males to sexual health support did not improve their uptake of STI testing or treatment; suggesting difficulty in supporting males to access sexual health services.

Mathews *et al.* (2015) found that attendance at a greater number of SRE sessions for young people was associated with an increased likelihood of visiting the SN for support. This highlighted a potential benefit of SNs delivering SRE in schools, unfortunately, less than 50% of schools completing the survey had received SRE support from their school nurse in the last year. For school staff who identified barriers to accessing sexual health support from the school nursing service, 37.5% were related to issues with time and the capacity of their school nurse. This was reiterated by the school nurses, with 37.5% identifying that time created a barrier to service delivery. Arguably a lack of time may limit the capacity of SNs to offer sexual health support. This highlights the benefit of incorporating sexual health support into other aspects of existing school nursing practice; for example, through drop-in clinics and general health assessments, as this should not create any additional time costs for school nurses and is in keeping with a holistic approach. This may also be beneficial for young people who were reported to prefer a holistic approach to sexual health services to help reduce the stigma associated with accessing sexual health support (Owen *et al.*, 2010).

Limitations and recommendations

It is recognised that the small sample size drawn upon in this study results in weak findings, which do not enable the findings to be generalised to a wider population. However, such a sample size is not surprising when considering the number of school nurses in practice and therefore it is positive that the survey completed by school nurses achieved a 100% response rate, alleviating non-response bias and minimising the risk of sample bias (Parahoo, 2014). A response rate of 42.8% for the

survey completed by school staff is considered by Mateo & Foreman (2014) to be inadequate. It is therefore recommended that further research is undertaken involving larger numbers of school nurses and school staff, along with parents and young people to ensure their views of the service are reflected.

The service recommendation from this study is for school nursing services to promote a preventative approach to sexual health service delivery, one way of achieving this would be to incorporate the administration of contraception, emergency contraception and STI self-testing kits into drop-in clinics, in line with national recommendations (RCN, 2012; DH, 2014a). This may promote access to the school nursing service by offering services that are wanted by young people (BYC, 2011). A local policy setting a standard for sexual health service delivery within school nursing would also be necessary to promote consistency across the service.

In conclusion, the role of the school nurse in sexual health includes delivering sex and relationship education, safeguarding children and young people who have experienced or are at risk of harm and leading school-based clinics offering sexual health promotion and contraception. For school nurses in the area studied, the service provision appears to be predominately reactive to safeguarding concerns and issues such as teenage pregnancy. However, there is scope for a more preventative approach with both school nurses and school staff outlining a vision for future service development that includes greater sex and relationships education, condom distribution and targeted group work for those identified as being at risk of STIs or pregnancy. However, this is reliant on school nurses having the time, training, confidence and resources to deliver such services. It is also reliant on them working collaboratively with school staff and parents who are ultimately the stakeholders determining if such interventions can take place in schools.

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Conflict of Interest:
None.

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